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Psychotherapy and Social Stratification†

An Empirical Study of Practice in a Psychiatric Outpatient Clinic

Leslie Schaffer* and Jerome K. Myers**

A COMMUNITY STUDY,[1] in which the authors have participated, has served to validate the not altogether novel, but relatively neglected proposition that *what happens therapeutically to a person who becomes a psychiatric patient is, to a significant degree, a function of his social-class position in the community.*[2] Patterns of psychiatric practice appear to be stratified in terms of the social class of the patients whom the psychiatrist treats, and techniques of therapy are applied differently to patients from different classes.

This proposition has been studied and confirmed in both institutional and clinic practice.[3] It has been shown to be probably valid not merely from one kind of institution to another, but within given categories of institutions and even with respect to the therapy of particular syndromes within given categories of institutions—for example, in the treatment of schizophrenic patients in state hospitals. There are indications, too, that the private practice of psychiatry is similarly stratified, with respect both to the class of patients treated and to the psychiatrists' theoretical orientations, beliefs, interests, and preferred techniques of treatment. The practice of psychoanalysts, for example, is largely restricted to Classes I and II. On the other hand, psychiatrists whose practices are largely drawn from classes lower on the social scale have something of a different philosophy of therapy, not to mention a usually far higher case-load. The latter variety of practitioner defines his role as a therapist in rather different terms from that of the psychoanalyst, and uses psychotherapeutic techniques generally characterized as "supportive," "suggestive," "directive," or "exhortative"—sometimes supplement-

[3] Robinson, Redlich, and Myers, reference footnote 1.

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[1] We refer to a project being carried out by members of the Departments of Psychiatry and Sociology at Yale University, under the direction of F. C. Redlich, M.D., and A. B. Hollingshead, Ph.D. The project, which is supported by USPHS Mental Health Grant MH 263 (R) is concerned with the relationships between some aspects of the social structure and psychiatric disorder. Preliminary reports, either published or awaiting publication, include the following: F. C. Redlich, A. B. Hollingshead, *et al.*, "Social Structure and Psychiatric Disorders," *Amer. J. Psychiatry* (1953) 109:729-734. H. A. Robinson, F. C. Redlich, and J. K. Myers, "Social Structure and Psychiatric Treatment (read at the 1953 annual meeting of the Amer. Orthopsychiatric Assn., to be published). A. B. Hollingshead and F. C. Redlich, "Social Stratification and Psychiatric Disorders," *Amer. Sociological Rev.* (1953) 18:163-169.

[2] The most complete account so far published of the notion of social-class position, as used here, will be found in Hollingshead and Redlich, reference footnote 1. The technique for determining social-class position is that devised by Hollingshead, whose "index of social position" is operationally derived from three factors—education, occupation, and ecological area of residence. These factors are weighted and scored, the final tallies then falling into one of five categories or social classes, numbered I through V in descending order. These classes are briefly characterized as follows: *Class I*—families of wealth, high educational status, and considerable prestige in the community. *Class II*—families in which the adults are, for the most part, college graduates and are occupied in the professions or as high-level executives. *Class III*—small shopkeepers, salesmen, white-collar and skilled workers; they have generally attained a high-school education, and some have had experience in business and trade schools, or a year or two at small colleges. *Class IV*—semiskilled workers and factory hands, the majority of whom are educated to less than the secondary level. *Class V*—unskilled factory hands and laborers, educated to primary level or less, who live in the tenement and cold-water-flat areas of the city.

ing these with the use of medications or physical methods of treatment. There is, moreover, not uncommonly a measure of mutual disregard between members of such practicing groups, which is expressed in many ways.

In order to account for these patterns, it has frequently been suggested that, by and large, it is the *economics* of class and practice which are responsible for both the differential availability of psychiatric care and the kinds of experiences undergone by persons who come into professional contact with psychiatrists.[4] This seems, at first blush, more than simply plausible—particularly in view of the limiting effects of uniformly high fees, on the one hand, and the varied ability to afford these fees, on the other. However, we do not believe that the stratification of practice can be explained exclusively on this basis.[5]

This paper presents some evidence that the social status of patients significantly affects their experience with psychiatrists in a situation where the economics of practice are more or less controlled. It is also concerned with a consideration of other possibly useful ways of thinking about the problems posed by these phenomena, with a view to suggesting further empirical research in this important area.[6]

[4] Other explanations of the relationships between psychiatric practice and social class, with special reference to psychoanalysis, have appeared in two recently published books. In *The "Why" of Man's Experience* (New York, Macmillan, 1950), Hadley Cantril has reproached psychoanalysts for neglecting the role of group conflict in neurosis and for sanctioning existing class relationships. It is to this that he attributes the "vogue" for psychoanalysis among the upper classes of many Western societies.

Robert Lindner suggests a related explanation in his *Prescription for Rebellion* (New York, Rinehart, 1952). Through the medium of a rather strained polemic, Lindner asserts that the psychiatrist's overwhelming attention to the problems of the upper classes arises from a "community of interests" with the group with which he is identified and with which he identifies himself. Thus arises, according to Lindner, the psychiatrist's preoccupation with adjustment and conformity for "mass-man"—which Lindner construes as an effort to preserve the *status quo* in which the psychiatrist allegedly thrives.

[5] In this connection, see R. M. Crowley, "A Low-Cost Psychoanalytic Clinic: First Year," *Psychoanalytic Quart.* (1950) 24:462-482.

[6] Work in progress by Redlich, Hollingshead, and their associates in the Yale project is concerned with some of these issues.

The Study

Setting

Principally in order to test the economic hypothesis of stratified psychiatric practice, we have made an empirical study of a psychiatric outpatient clinic in a major teaching hospital. It was the explicit policy of the clinic to exclude patients who could afford private care;[7] patients were also required to be residents of the community served by the hospital. In addition, the clinic's policies were directed toward the selection of patients who would provide "good teaching material" in terms of their useful participation in psychotherapy and who would probably respond to a relatively brief psychotherapeutic experience.

The clinic's staff was oriented toward the use of brief techniques of expressive psychotherapy (that is, psychoanalytically-oriented, or "insight," therapy) in relatively minor psychiatric disorders, principally the neuroses.

The clinic served two major functions: the postgraduate training of psychiatric residents and community service. It also provided training for social work students and brief clerkships for third-year medical students.

The mechanics of admission to the clinic were not unusual. Applicants, no matter how referred, were screened to determine financial eligibility before arriving in the clinic and then seen for an "intake-interview." This was generally conducted by a social worker, psychiatrist, or resident, and was essentially a diagnostic interview during which attempts were made to determine the patient's expectations of therapy, his "motivation" for seeking psychiatric help, and his capacity usefully to integrate the kind of experience provided by the clinic. Briefly, there was an attempt to answer the question: Is this a suitable patient for expressive psychotherapy?

[7] Applicants are screened by hospital clerks prior to their visit to the clinic. Although the assessment of their finances takes into account both income and commitments, the general level above which patients are excluded is circa $5,000 total annual family income. Further, fees are scaled according to a patient's means; they vary from a maximum of $5.00 per visit to as little as $.50, or occasionally nothing.

The intake-interview was routinely followed by the presentation of the case at an intake-conference, which was generally attended by all members of the clinic staff and supervised by the physician in charge. As a rule, the administration of the clinic was democratic rather than authoritarian, and both authority and responsibility were widely delegated. Decisions made at the conferences were established by consensus rather than by authority, and residents and others were largely free to choose [8] those patients whom they wished to see, and to reject others. Furthermore, the situation was such that the demand for therapy generally exceeded the clinic's potential in terms of available therapist-hours.

Given the patient's acquiescence or collaboration, the assigned therapist enjoyed a considerable measure of autonomy with respect to his treatment, including the duration and intensity of his contacts. While supervision was generally available, it seems seldom to have been imposed.

Available therapists fell into several categories. The largest number were residents in the second year of a three-year training program organized by the university department which staffed and administered the clinic. There were two senior psychiatrists: one was the physician in charge who confined his activities to teaching, administration, and consultation work; the other participated in these activities but also undertook therapy with clinic patients. Transient personnel included medical students who acted as clinical clerks over four-week periods, treating patients on a once-a-week basis, and a few graduate students from the associated psychology department who undertook some treatment under supervision from their own faculty. Social workers and social work students rarely treated patients in psychotherapy, their activities being mainly those of dealing with referrals, intake-interviewing, and case-work with families. Another significant group consisted of the supervising psychiatrists; these were generally psychoanalysts or analytically-trained psychiatrists with whom residents spent one or two hours per week reviewing current cases.

[8] They were "free to choose" only in a manner of speaking. The extent to which there was anything that could properly be referred to as "freedom of choice" may become clear from what follows.

Data

The data available for this study consisted primarily of the clinic's records of consecutive applications over a period of one year. These were occasionally augmented by information obtained directly from the patients, when, for example, the records did not contain information necessary for class-typing. One of us became familiar with the setting by participating in intake-conferences over a period of some months, as well as through informal relationships with staff members and residents.

Data were found comparable, from record to record, only in terms of identifying material—such as the age, sex, and address of patients—and statistical information in the form of rigorously maintained notes regarding when and by whom patients were seen. In almost every record there was a note regarding decisions made at intake-conferences which included the name or category of the assigned therapist, or the kind of disposition suggested if the patient was not accepted for psychotherapy.

Clearly, from data of this order, the extent to which a patient's experience in the clinic can be rated is limited. Therefore we have contented ourselves with crudely measuring such experiences in terms of the relative status of the therapist, and the intensity and duration of the contact. While the drawbacks of such a scheme are readily apparent, it permits operational definition and statistical analysis, and thus is repeatable. For these purposes, it seems justifiable to rate differently a psychotherapy which included a member of the clinic's senior staff and which lasted for six months, from another in which a patient was seen over a period of four weeks by a medical student. It is clear, too, that this kind of information does not permit us to make statements about the degree to which any contact was in fact therapeutic. We are more

concerned here with the kind of effort made, with success and failure in establishing relationships, than with the effectiveness of therapy.

In view of the problem of comparability of content of records, we have considered only two diagnostic categories: the psychoneurotic disorders (including symptom, character, and psychosomatic disorders) and the psychotic reactions. The latter consisted largely of so-called ambulatory schizophrenics together with occasional depressive reactions.

The following categories, which emerged from the census of all patients applying for therapy over the period studied, have not been considered here: (1) patients referred for consultation only, where this was quite explicitly the purpose of the contact; (2) patients considered to have nonpsychiatric syndromes and referred to other clinics; (3) patients considered to need hospitalization and referred to state hospitals, generally following emergency commitment; (4) patients whose referral was never followed up by their appearance at the clinic; and (5) patients who, following inadequate screening, were discovered to be able to afford private care.

Over the year studied, excluding the group just outlined, a total of 195 patients applied for therapy in the clinic.[9] Of these, 47 were considered to be psychotic or probably so, while the remaining 148 were considered to be psychoneurotic. These people came from all social classes, save the uppermost, as shown in Table 1.

The ways in which patients were referred to the clinic is shown in Table 2. Since there were no patients from Class I, this class is automatically excluded from the following generalizations. Persons from all other social classes were referred from all sources. The relatively high percentage of patients classed as IV and V who were referred from other clinics in the hospital probably reflects the high proportion of patients from these classes seen in those clinics. Family doctors sent patients from all social classes, and patients from all classes referred themselves or were referred by their families or friends. In this sample, relatively few Class V patients were referred by psychiatrists or psychiatric agencies. It is clear, however, from what follows that the ways in which patients were referred had little to do with their subsequent experience in the clinic, and the social-class differences in referral are not significant in this respect.

TABLE 1

PERCENTAGE DISTRIBUTION BY SOCIAL CLASS OF PERSONS APPLYING FOR TREATMENT AND OF GENERAL POPULATION OF COMMUNITY SERVED BY HOSPITAL CLINIC

Social Class*	Percent of Patient Population	Percent of General Population
I	0.0	3.0
II	9.3	8.4
III	28.4	20.5
IV	39.3	49.8
V	23.0	18.4
TOTAL	100.0	100.1

* For a description of the different social classes, see reference footnote 2.

The influence of the class positions of patients in determining patterns of selection is manifested primarily in the decisions made at the intake-conferences. The kinds of decisions made and the assignment of patients to different categories of therapists are shown in Table 3, presented here without reference to diagnosis. It is apparent from this table that there is a significant relationship between the social class of applicants and their recommended disposition. The significance of these findings is thrown into bolder relief if decisions made are subsumed under only two categories: (1) patients accepted for individual psychotherapy with senior staff members and residents; and (2) patients subject to all other decisions and modes of disposal. In these terms, more than 64 percent of Class II and 55 percent of Class III patients were accepted for individual psychotherapy with

[9] Of the 195 patients reviewed here, 12 could not be assigned to class positions for want of sufficient data. In a very few cases, class position was assigned on the basis of two factors where the third was wanting; for instance, some of these patients lived in towns not ecologically mapped. The 12 cases whose class position is unknown have not been included in the statistical analysis. Of these 12 cases, one was accepted for individual psychotherapy with a resident and two for group therapy; the others were rejected.

senior staff members and residents, and more than 66 percent of Class IV and 97 percent of Class V patients were rejected.

While neurotic patients were more frequently accepted for treatment in the clinic than were those considered to be psychotic (allowing for the disproportionate representation of the two groups), stratified patterns of decisions occur within both categories to a statistically significant degree.[10] It may be noted in passing that the class-distribution of psychotics who applied for treatment was similar to that of the neurotics.

TABLE 2

REFERRING AGENCY AND SOCIAL CLASS

Referring Agency	Social Class of Patients								Total	
	II		III		IV		V			
	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Family doctor.....	3	*17.6*	15	*28.8*	23	*31.9*	12	*28.6*	53	*29.0*
Self, family, or friends.....	4	*23.5*	18	*34.6*	11	*15.3*	11	*26.2*	44	*24.0*
Medical and other clinics.....	2	*11.8*	7	*13.5*	22	*30.6*	12	*28.6*	43	*23.5*
Psychiatrists	3	*17.6*	4	*7.7*	4	*5.6*	0	*0.0*	11	*6.0*
Psychiatric clinics and hospitals.....	2	*11.8*	4	*7.7*	3	*4.2*	1	*2.4*	10	*5.5*
Social agencies.....	1	*5.9*	3	*5.8*	8	*11.1*	3	*7.1*	15	*8.2*
Unknown	2	*11.8*	1	*1.9*	1	*1.4*	3	*7.1*	7	*3.8*
TOTAL	17	*100.0*	52	*100.0*	72	*100.1*	42	*100.0*	183	*100.0*

$\chi^2=15.42$*
$p<.10$

* Unknown cases were not used in computing chi-square. Because of the paucity of cases, the categories of "psychiatrists," "psychiatric clinics and hospitals," and "social agencies" were combined to form one category for statistical analysis.

TABLE 3

CONFERENCE DECISIONS AND SOCIAL CLASS OF APPLICANTS FOR THERAPY

Decisions	Social Class of Patients								Total	
	II		III		IV		V			
	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Senior staff.....	6	*35.3*	9	*17.3*	2	*2.8*	0	*0.0*	17	*9.3*
Residents	5	*29.4*	20	*38.5*	22	*30.6*	1	*2.4*	48	*26.2*
Medical students.....	0	*0.0*	5	*9.6*	19	*26.4*	10	*23.8*	34	*18.6*
Other therapists*.....	1	*5.9*	4	*7.7*	7	*9.7*	3	*7.1*	15	*8.2*
Referred to other agencies	2	*11.8*	9	*17.3*	3	*4.2*	1	*2.4*	15	*8.2*
No recommendations (rejection)	2	*11.8*	5	*9.6*	16	*22.2*	27	*64.3*	50	*27.3*
Decision unknown....	1	*5.9*	0	*0.0*	3	*4.2*	0	*0.0*	4	*2.2*
TOTAL	17	*100.1*	52	*100.0*	72	*100.1*	42	*100.0*	183	*100.0*

$\chi^2=63.73$†
$p<.001$

* Social workers, students, and psychology students. This also includes a small number of patients accepted for group psychotherapy with residents.

† Cases in which decisions were unknown were not used in the calculation of the chi-square. Also, because of the paucity of cases, the category "senior staff" was combined with "residents," and the category "other therapists" with "referred to other agencies."

If therapists are ranked according to their status positions within the clinic, as shown in Table 3, quite striking differ-

[10] The chi-square test was used in all computations to determine whether significant differences existed between frequency distributions. Significance is defined at the .05 level of confidence.

ences are found in the classes of patients treated by differently ranked therapists. Generally, the senior staff treated patients from Classes II and III; the residents treated a few Class II patients, but the majority of their patients were from Classes III and IV; and the medical students (the only group who had little or nothing to say about their assignments) treated Classes IV and V primarily. It may be that this phenomenon reflects the established pecking-order within the clinic.

Further significant correlations are found between the social class of patients and their duration of contact with the clinic. Table 4 shows an analysis of these findings. Of the 63 patients seen over periods of one week or less (generally on only one occasion), 47 (nearly 75 percent) were from Classes IV and V. Conversely, of the 27 patients who maintained contact for more than 25 weeks, 20 (nearly 74 percent) were from Classes II and III. The significance of these findings is highlighted when the disproportionate numbers from each class are considered.

TABLE 4

DURATION OF CONTACT WITH THE CLINIC AND SOCIAL CLASS OF PATIENTS

Duration of Contact	Social Class of Patients									
	II		III		IV		V		Total	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent
One week or less.....	2	*11.8*	14	*26.9*	27	*37.5*	20	*47.6*	63	*34.4*
2-4 weeks.....	2	*11.8*	7	*13.5*	17	*23.6*	6	*14.3*	32	*17.5*
5-9 weeks.....	3	*17.6*	7	*13.5*	7	*9.7*	10	*23.8*	27	*14.8*
10-24 weeks.....	5	*29.4*	9	*17.3*	16	*22.2*	4	*9.5*	34	*18.6*
25 weeks and over....	5	*29.4*	15	*28.8*	5	*6.9*	2	*4.8*	27	*14.8*
TOTAL	17	*100.0*	52	*100.0*	72	*99.9*	42	*100.0*	183	*100.1*
							χ^2=17.50*			
							p<.01			

* Because of the small number of cases involved, the categories "one week or less," "2-9 weeks," and "10 weeks and over" were used in the calculation of the chi-square.

Summary of Findings

On the basis of these findings, it appears that the experience of patients in this clinic, where the economics of treatment is largely inconsequential for those eligible, is to a significant degree a function of their social-class positions in the community. Persons from all classes, with the exception of the uppermost, applied for therapy; they were referred by all sources, including themselves—the only gross exception being the absence of Class V patients referred by psychiatrists.

The data have been analyzed with reference to other conceivably relevant factors about which information was obtainable. It has been shown that the source of referral, the age and sex of the patient, the diagnosis (in terms of the two categories considered here—neurosis and psychosis), and the variety of intake-interviewer (such as social worker or physician) are not significantly related to the patient's experience in the clinic.[11] Unfortunately, the number of cases in the series did not allow control for individual therapists.

In other words, to a significant degree, the higher a patient's social-class position was in the community, the greater were his chances of being accepted for psychotherapy, of being assigned to a relatively experienced therapist occupying a high status position within the clinic, and of maintaining contact with the clinic.

DISCUSSION

The analysis of these data seems to indicate that propositions based principally on the economics of class and psychiatric practice are neither necessary nor sufficient to account for stratified patterns of psychiatric care.

[11] Reference is made here to statistical control for other conceivably relevant factors about which data was available. Details of the statistical analysis are omitted here for the sake of clarity and brevity.

In discussing the phenomena shown by the data and the problems they pose, we will attempt to indicate, rather less than comprehensively, other avenues of empirical enquiry which may lead to generally valid explanations. This may be done by suggesting, in a rather tentative fashion, other possibly explanatory conceptions. It is important to stress that these are not deducible from the study data, nor indeed from any data so far available in systematic form. Rather, the data will be used as a stage for the rehearsal of other ways of thinking about the problems posed by the study.[12] We will continue to refer to the clinic situation studied, although some of what follows may prove to be more generally applicable.

The clinic phenomena may be considered as resulting from the interaction of members of the clinic group and a procession of patients, and thus as essentially reciprocally determined. It is important to note, however, that in attempting to explain the results of these sequences of interaction, it is necessary to take into account the distribution of power—that is, the extent to which patients and therapists participate in making the kinds of decisions manifested in the patterns demonstrated here. Power, in this sense, was initially vested chiefly in the clinic group. For example, one set of decisions has to do with the acceptance of patients for psychotherapy and their assignment to therapists. A patient's participation in this process would seem limited to his coming to the clinic; besides influencing decisions made about him by explicitly seeking help in one or another way, he has little if anything to say about whether he is accepted, or about how and by whom he will be treated. Only if he is accepted does he resume a measure of participation in making decisions—in terms of accepting his assignment and continuing to come to the clinic, and in terms of his dealings with his therapist.

We shall approach the problem of discussing these phenomena—which we conceive of as the patterns of resolution of reciprocally determined processes of interaction—by using, in turn, three points of reference: (1) the patients; (2) problems of communication in the patient-therapist interaction; and (3) the therapists and the social structure of the clinic.

The Patients

The meaning of mental disorder and its social consequences vary historically within given cultures—from group to group within a given culture as well as from one culture to another.[13] Different kinds of orientations toward the problem of mental disorder include definitions of what constitutes disorder and of the social role of the disordered person. Further, they include conceptions of the etiology of mental illness and of its treatment and control, as well as of the allocation of responsibility for the care of the mentally disordered.

Although we have, so far, no systematic knowledge of this issue within our own culture, it seems probable that persons from different groups define mental disorder in rather different terms and entertain remarkably disparate notions about psychiatrists and their roles and practices. This implies, then, the existence of a state

[12] Other implications of status position and social mobility for psychotherapy have been suggested by Jurgen Ruesch. In his paper on "Social Technique, Social Status and Social Change in Illness" (in *Personality in Nature, Society and Culture,* edited by C. Kluckhohn and H. A. Murray; New York, Knopf, 1950), Ruesch has drawn attention to the prognostic implications of social mobility for psychotherapy, as well as to the possibility that status position influences the ways in which persons manifest mental disorder.

In our study, we were not able to gather data about social mobility in a sufficient number of cases to enable us to make statements about its role in determining the behavior of either patients or therapists. We have, however, been impressed, in a few cases, with what may be a relationship between a high degree of vertical mobility in therapists, and their behavior regarding the critical appraisal and selection of applicants for psychotherapy: it seems that their standards in this respect far exceed those of their less socially mobile colleagues.

Since the completion of this paper, Ruesch's article on "Social Factors in Therapy" has been published, much of which is pertinent to issues taken up here. J. Ruesch, "Social Factors in Therapy: A Brief Review," pp. 59-93; in *Psychiatric Treatment* (Proc. Assn. for Research in Nervous and Mental Disease); Baltimore, Williams & Wilkins, 1953. In this regard, see also J. Ruesch and G. Bateson, *Communication;* New York, Norton, 1951.

[13] It has also been stressed that what is considered to be "normal" and "healthy" varies in a similar manner. See, for example: F. C. Redlich, "The Concept of Normality," *Amer. J. Psychotherapy* (1952) 6:551-576. Kingsley Davis, "Mental Hygiene and the Class Structure," PSYCHIATRY (1938) 1:55-65.

of affairs somewhat resembling that which prevails in contemporary professional psychiatry.

It is, for example, not uncommon in the clinic studied, for psychiatrists to see Class V neurotic patients who, more or less explicitly, describe themselves as "sick" in a traditionally medical sense, expecting "the doctor" to respond accordingly. The psychiatrist, then, is supposed to provide essentially instrumental remedies in the form of "something to quieten the nerves," "tonics," "injections," or occasionally "shock therapy." If a patient desires a relatively noninstrumental response, he is likely to conceive of it in terms of "answers" for obscurely stated problems, advice, explanations, or formulae for success in areas of failure. Furthermore, the patient expects such items to be supplied extemporaneously by a presumably omniscient stranger on the basis of minimal information and a very brief acquaintanceship. Whether the psychiatrist is regarded as some kind of magician, as a "nerve doctor," or as a "mind doctor," it is frequently singularly remote from the dynamically-oriented psychiatrist's conception of himself and his role as a therapist. In a situation which includes such a neurotic patient and a therapist of this order and persuasion, disintegration may proceed quite rapidly. The psychiatrist may tentatively submit to the patient that "the symptoms" reflect emotional difficulties, rather than indicating that anything is physically wrong, and that the patient will not be helped by the remedies he is apparently seeking. He may indicate his reluctance to provide advice without knowing a great deal more about the patient. Such an approach may be received by the patient in an anything but enthusiastic fashion. Indeed, the patient may take it as a frank affront, inferring that the therapist believes there is nothing *really* the matter with him. On occasion, the patient may be reminded of experiences with relatives or friends who have expressed their sentiments toward him in terms of their convictions that he is imagining things and that all he has to do is to stop thinking about himself and pull himself together. The psychiatrist's further suggestion that sometimes it helps to discuss these things and to try to understand their meaning and origin, may be reluctantly entertained until it becomes clear that it is the patient who is expected to talk while the psychiatrist apparently does nothing but listen. At this point the patient may become quite certain that what he has previously heard about psychiatrists is merely a fraction of the truth, and he may leave with the feeling that at least this problem has been clarified.

Therapists describe a distinct "lack of rapport" with such patients, often sensing not only that there is a considerable distance between them and himself, but that the patient is so hostile and suspicious that the prospects for useful short-term collaboration are hopeless. Such patients are said to "lack insight," to have "no motivation" for psychotherapy or change—this in spite of their having come to the clinic and often having referred themselves. Each, then, rejects, in rather different terms, what he fancies he understands of the other.

At the opposite pole, from the therapist's point of view, is the "cultured," literate[14] Class II patient who enters therapy already familiar with the notion that somehow one overcomes neurotic ways of living through experience in a therapeutic relationship in the medium of which one comes to understand oneself. Such a patient comes into therapy with something of a shared basis for collaboration with the therapist: his definition of roles in therapy is much like the therapist's, and he holds in common with the therapist something of the ideology of contemporary dynamic psychiatry. With

[14] On occasion, *education* has been singled out as the key component of social class responsible for the stratification of psychotherapeutic practice—as well as for the desire to undergo psychotherapy evidenced by members of the middle and upper classes. There are many difficulties in assessing the merits of such an argument. For example, there are indications that education as a value varies from class to class, and that persons from different social classes use education in different ways and for different purposes—suffering the effects of educational experiences in different terms. The question then arises: Does the middle-class person accept psychotherapy because the degree to which he is educated or enlightened permits him to comprehend its meaning, *or* does he accept it because it falls easily into place in his value-system, as did education?

these patients, therapists are more likely to experience a feeling of belonging in the situation, which tends to lead to continuation of the relationship. Therapists describe this kind of patient as "well-motivated," as having "considerable capacity for self-scrutiny"—that is, as having a praiseworthy gift for verbalizing responses —or as "psychologically-minded." He is considered to be both treatable and worthy of treatment.[15] One finds suggestions, then, that such valued gifts are more commonly found in Class II—that is, among a group which approximate that to which psychiatrists belong.[16]

Problems of Communication

In this clinic, the more remote the patient's class from the psychiatrist's, the less are the chances that a psychotherapeutic relationship will be initiated, and if initiated, continued. One of the problems that arises is: To what extent can persons occupying positions remote from each other in the class structure communicate meaningfully at the level of abstraction implied in the process of expressive psychotherapy? If it is justifiable to assume the existence of a culture of classes, then one may assume that persons from different classes undergo different kinds of experiences, integrating these experiences in different terms. Thus they have more-or-less different frames of reference for human relations, or different kinds of orientations for acting with others. If this means anything at all, then presumably the greater the distance between classes, the greater the difficulties in role-taking and communication between persons from these classes. Problems of this kind have received attention from time to time in the literature,[17] although specific references to such problems in psychotherapy are rare.[18]

The existence of such a problem of communication between members of different social classes was emphasized by G. H. Mead, in his discussion of the role of the leader in society:

> Occasionally a person arises who is able to take in more than others of an act in process, who can put himself into relation with whole groups in the community whose attitudes have not entered into the lives of others in the community. He becomes a leader. Classes under a feudal order may be so separate from each other that while they can act [together] in certain traditional circumstances, they cannot understand each other; and then there arises an individual who is capable of entering into the attitudes of the other members of the group. Figures of that sort become of enormous importance because they make possible communication between groups otherwise completely separated from each other. . . . a community which lies entirely outside your own community, that has no common interest, no cooperative activity, is one with which you could not communicate.[19]

This problem of communication between members of remotely related groups seems important enough to warrant further empirical investigation.

The capacities that characterize Mead's "leader" are, by implication, uncommon. They occur again under a somewhat dif-

[15] Save by implication, we have not considered here the values of the individual therapists, in terms of the kinds of persons considered therapeutically worth-while. Freud made his position quite explicit on several occasions in this regard. For example, in an early paper "On Psychotherapy" (written in 1904, reprinted in *Collected Papers* 1:249-263; London, Hogarth Press, 1924), Freud states: ". . . those patients who do not possess a reasonable degree of education and a fairly reliable character should be refused [therapy]. . . . It is gratifying that precisely the most valuable and highly developed persons are best suited for these curative measures . . ." (pp. 257-259). In his paper "Turnings in the Ways of Psycho-Analytic Therapy" (1919, in *Collected Papers* 2:392-402), Freud discusses the then current limitations of psychoanalytic psychotherapy and mentions the need for modifications of technique in order to treat persons not considered suitable for intensive therapy: ". . . the necessities of our own existence limit our work to the well-to-do classes. . . . At present we can do nothing in the crowded ranks of the people, who suffer exceedingly from neuroses" (p. 401). Speaking of the establishment of free clinics, he adds: "The task will then arise for us to adapt our technique to the new conditions. I have no doubt that the validity of our psychological assumptions will impress the uneducated too, but we shall need to find the simplest and most natural expression for our theoretical doctrines" (pp. 401-402). After alluding to the possible necessity for material support for the impoverished neurotic, Freud concludes: "It is very probable, too, that the application of our therapy to numbers will compel us to alloy the pure gold of analysis plentifully with the copper of direct suggestion . . ." (p. 402).

[16] Psychiatrists and other professional persons in the clinic would be generally assigned to Hollingshead's Class I or Class II.

[17] Ruesch, reference footnote 12.

[18] "I have been able, without affecting their individuality, to help persons with whom I had nothing in common, neither nationality, education, social position nor outlook upon life in general." S. Freud, "Turnings in the Ways of Psycho-Analytic Therapy," reference footnote 15; p. 399.

[19] George Herbert Mead, *Mind, Self and Society;* Chicago, Univ. of Chicago Press, 1934; pp. 256-258.

ferent guise in Harold Lasswell's commentary on "the democratic character." Lasswell notes that:

> Such a person transcends most of the cultural categories that divide human beings from one another, and senses the common humanity across class and even caste lines within the culture, and in the world beyond the local culture.[20]

It may be that persons considered to be unusually expert therapists have something of gifts such as these, including an unusually broad role-taking repertory. Such persons would, however, seem to be quite rare. Masserman, in discussing communication, has noted the existence of this kind of problem:

> . . . disparities of connotation also increase rapidly as social and cultural gaps between individuals and groups become wider; indeed such difficulties in communication have constituted barriers to understanding and fellowship that are of transcendent (and sometimes tragic) importance.[21]

The Therapists [22]

Something of the therapists' orientation and persuasion has already been mentioned. However, in order to grasp their participation in the interaction process with patients from various social levels, it is necessary to consider their actions in terms of their integration within the social structure of the clinic group.

For the purposes of this discussion, we shall consider the social structure of the clinic in less than comprehensive terms, and conceive of it as a system of reciprocal needs of staff members and demands made upon them—"needs" and "demands" being construed here as functions of the kinds of relationships which, as it were, shape the system. Such needs and demands fall generally into two categories. One category is not specifically related to the situation qua psychiatric clinic; it includes the general or personal needs and demands of the therapists and others. For example, into this category fall both conscious and unconscious needs such as needs for success or failure, for deference, prestige, love, and admiration. Such needs have implications for professional activities within the clinic. For instance, residents may tend to choose patients manifesting particular kinds of neurotic behavior, or patients of only one or the other sex. The other category is more specifically related to the kind of activity for which the clinic is set up, and to the situation as a teaching and training center. For instance, one set of specific demands made upon therapists which falls into this category is the subject of a great deal of explicit discussion and teaching: this is that therapists should fulfill generally shared and powerful expectations regarding the kind of psychotherapy they should do, as well as their attaining a level of competence in this direction. In this clinic, the prototype for the approved model was that of the psychoanalyst. Implicit in such a set of demands and expectations is the definition of a pattern of roles for the therapeutic situation, and thus a set of expectations for the patient.

Demands made upon therapists originate in three distinct groups of other persons—the patients, the colleagues or peer group, and the supervisors and teachers—as well as in the therapist himself. Only one of these groups is readily influenced by the therapists—to wit, the patients. It would seem likely, then, that a therapist's choice of patients, his decisions about initiating and continuing therapy, as well as his evaluative appraisal of patients in terms of their "motivation" for psychotherapy, may be functions of the therapist's other relationships within the clinic, as well as of his self-derived needs. In other words, we would anticipate that in such a clinic setting, a therapist would tend to select patients who would in some way facilitate his fulfilment of other-originated demands as well as his own general needs. Thus therapists tend to seek, in a sense quite wittingly, patients who will allow them

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[20] "The Democratic Character"; in *The Political Writings of Harold Lasswell;* Glencoe, Ill., Free Press, 1951.

[21] Jules Masserman, *Principles of Dynamic Psychiatry;* Philadelphia, W. B. Saunders, 1946; pp. 165-166.

[22] Some of what follows has been elaborated clinically by Fromm-Reichmann. See, for example, Frieda Fromm-Reichmann, *Principles of Intensive Psychotherapy;* Chicago, Univ. of Chicago Press, 1950; part 1.

to enact the approved role of an "insight therapist."

The actions of therapists, then—insofar as they involve making the kinds of decisions considered here—are conceived of as representing a compromise solution to a galaxy of conflicting demands; and these demands become apparent only when the therapist's position in the clinic system is defined.[23] Considered in these terms, it is perhaps worth mentioning the possibility that the inexperienced therapist's preoccupation with the patient's gaining insight, coupled with a tendency to supply interpretations rather liberally, may also represent a compromise solution to a conflict situation—with one vector representing the patient's demands to be "given something," and the other representing the therapist's own structured notions about fulfilling what he conceives to be the role of the analytically-oriented therapist.

[23] If such a mode of analysis is relevant to this problem, then we would anticipate that in differently structured and oriented clinics, patterns of, say, selection of patients would be different from the pattern found here. If practice is influenced by social stratification in such clinics, it may be that the influences would be manifested in other ways.

Conclusions

A series of phenomena have been described which indicate a significant relationship, in a psychiatric clinic, between psychotherapeutic practice and social class. In discussing these findings, which at present cannot be explained on the basis of any systematic empirical work, we have pointed to three possibly useful points of reference which are by no means separate from each other: (1) the patient; (2) problems of communication in the patient-therapist interaction; and (3) the therapist in the social structure of the clinic. It seems to be evident that an economic theory of the stratification of psychiatric practice does not have general validity, and we believe that the relevance of the economic component of social class in this connection is more limited than has been thought. It may be that findings such as these contain significant implications for psychiatric teaching and for the planning of treatment centers in the community.

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